State of Connecticut
Office of Health Care Access
CON Determination Form
Form 2020

All persons who are requesting a determination from OHCA as to whether a CON is required for their proposed project must complete this Form 2020. The completed form should be submitted to the Commissioner of the Office of Health Care Access, 410 Capitol Avenue, MS#13HCA, P.O. Box 340308, Hartford, Connecticut 06134-0308.

SECTION I. PETITIONER INFORMATION

If this proposal has more than two Petitioners, please attach a separate sheet, supplying the same information for each Petitioner in the format presented in the following table.

	Petitioner	Petitioner
Full Legal Name	Gaylord Hospital, Inc	
Doing Business As	Gaylord Hospital	
Name of Parent Corporation	Gaylord Hospital, Inc.	
Petitioner's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail	PO Box 400 Gaylord Farms Rd Wallingford, CT 06492	
What is the Petitioner's Status: P for profit and NP for Nonprofit	NP	
Contact Person, including Title/Position: This Individual will be the Petitioner's Designee to receive all correspondence in this matter.	Ms. Jacqueline Epright Director of Business Development Support	
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail	Gaylord Farm Rd PO Box 400 Wallingford, CT 06492	

Contact Person's Telephone Number	203-284-2725
Contact Person's Fax Number	203-741-3408
Contact Person's e-mail Address	jepright@gaylord.org

SECTION II. GENERAL PROPOSAL INFORMATION

a. Proposal/Project Title:
Reconfiguration of Outpatient Services

b. Location of proposal, identifying Street Address, Town and Zip Code:
1 Long Wharf Drive New Haven, CT is the site to be closed. Existing office locations that will serve this area are North Haven, Woodbridge, Wallingford and Guilford.

c. List each town this project is intended to serve:
This location serves individuals from New Haven, West Haven, East Haven, Milford, Hamden and North Haven

d. Estimated starting date for the project:
Closure of this site on 9/20/06

e. Type of Entity: (Please check *E* for Existing and *P* for Proposed in the boxes that apply)

E	P		E	P		E	P	
☐	☐	Acute Care Hospital	☐	☐	Imaging Center	☐	☐	Cancer Center
☐	☐	Behavioral Health Provider	☐	☐	Ambulatory Surgery Center	☐	☐	Primary Care Clinic
☐	☐	Hospital Affiliate	☒	☐	Other (specify): Chronic Disease Hospital			

SECTION III. EXPENDITURE INFORMATION

a. Estimated Total Project Cost:
no associated dollars to close this office

b. Please provide the following breakdown as appropriate: (may not represent the aggregate shown above)

Medical Equipment Purchases	
Major Medical Equipment Purchases	
Non-Medical Equipment Purchases*	
Land/Building/Asset Purchases	
Construction/Renovation	
Other (Non-Construction) Specify:_____	
Total Capital Expenditure	
Medical Equipment - Fair Market Value of Leases	
Major Medical Equipment - Fair Market Value of Leases	
Non-Medical Equipment - Fair Market Value of Leases*	
Fair Market Value of Space –Capital Leases Only	
Total Capital Cost	
Total Project Cost	None
Capitalized Financing Costs (Informational Purpose Only)	

* Provide an itemized list of all non-medical equipment to be purchase and leased.

Major Medical and/or Imaging Equipment Acquisition:

Equipment Type	Name	Model	Number of Units	Cost per unit
NONE				

Note: Provide copy of the vendor contract or quotation for the medical equipment.

c. Check each applicable financing method or funding source to be used for the proposal:

☐ Petitioner's Equity	☐ Capital Lease	☐ Conventional Loan
☐ Charitable Contributions	☐ Operating Lease	☐ CHEFA Financing
☐ Funded Depreciation	☐ Grant Funding	☐ Other (specify): _____

SECTION IV. PROPOSAL DESCRIPTION

Please provide a description of the proposed project, highlighting each of its important aspects, on at least one, but not more than two separate 8.5" X 11" sheets of paper. At a minimum each of the following elements need to be addressed, if applicable.

1. Identify the types of services currently provided. If applicable, provide a copy of each Department of Public Health license held by the Petitioner.

2. Identify the types of services that are being proposed and what DPH licensure categories will be sought, if applicable?

3. Identify the current population served and the target population to be served.

4. Identify the entity that will be providing the service(s).

5. Identify the entity that will be responsible for the billing of the service(s) relating to this proposal.

6. Identify the entity that owns/leases or will own/lease the physical space of the proposed equipment/service?

7. If there is more than one entity involved in this proposal, please provide copies of any and all existing or proposed contracts or written agreements entered between the two entities that relate to the proposal.

8. Provide a list that identifies the name of each petitioning or affiliate entity involved with this proposal.

9. Provide a copy of the chart of organization for each individual petitioning entity or affiliate and a corporate chart of organization, if applicable.

10. Provide a narrative that addresses the relationship of each petitioning or affiliate entity with the other entities involved with this proposal.

11. Who are the current payers of this service and identify any anticipated payer changes when the proposed project becomes operational?

Please See Attachment A

Attachment A

Gaylord Hospital
CON Determination

Gaylord Hospital is reconfiguring its outpatient services in order to gain operating efficiencies. This reconfiguration includes the closure of the New Haven office located at 1 Long Wharf Drive on September 20, 2006. This office must be closed and vacated by the end of the Hospital's fiscal year which is September 30, 2006. The services provided at this office are not licensed by the Department of Public Health.

The 1 Long Wharf Drive office provides physical therapy, occupational therapy and physiatry services. The site serves residents of New Haven, West Haven, East Haven, Milford, Hamden and North Haven. This office closure will not affect the scope of services provided by Gaylord or its ability to serve patients from the communities listed above. Our existing practices at 8 Devine Street in North Haven, the Jewish Community Center on Amity Road in Woodbridge, the main hospital campus in Wallingford and our office on Soundview Drive in Guilford have the capacity to absorb the volume of patients we have been seeing in New Haven. The North Haven and Woodbridge offices are located on bus lines and are 8 miles and 6 miles respectively from the Long Wharf site. In addition, we have just received notification that the "My Ride" program will begin serving our main hospital campus in Wallingford which is not on a bus line. We are currently in discussion with the Hill Health Center to contract out physiatry hours to them in order to continue to provide easy access to services for their patients. We are prepared to open a smaller site in the New Haven/West Haven area if necessary and appropriate to address patient service requirements.

We respectfully request that OCHA determine that no CON is required for the reconfiguration of Gaylord's outpatient services as we will be providing the same level of service to the same service area.

SECTION V. AFFIDAVIT

To be completed by each Petitioner

Petitioner: James J. Cullen

Project Title: Outpatient Reconfiguration

I, James J. Cullen, CEO
(Name) (Position – CEO or CFO)

of Gaylord Hospital being duly sworn, depose and state that the
(Organization Name)

information provided in this CON Determination form is true and accurate to the best of my

knowledge, and that Gaylord Hospital, Inc. complies with the appropriate
(Facility Name)

and applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-

486 and/or 4-181 of the Connecticut General Statutes.

8/29/06

Signature Date

Subscribed and sworn to before me

on August 29, 2006

Notary Public/Commissioner of Superior Court

My commission expires: MY COMMISSION EXPIRES 03/31/2011

Form 2020
Revised 7/06